March 26, 2002

Ms. Mary Kennedy
Medicaid Director
Assistant Commissioner for Health Care
Minnesota Department of Human Services
444 Lafayette Road North
Saint Paul, MN 55155

Dear Ms. Kennedy:

Thank you for your letter of December 20, 2001, concerning budget neutrality for the 3-year extension of demonstration project No. 11-W-00039/5 entitled "Minnesota Prepaid Medical Assistance Project Plus" (PMAP+), which was approved on October 2, 2001. Approval of the extension permits the PMAP+ program to proceed as authorized under section 1115(e) of the Social Security Act from July 1, 2002, to June 30, 2005.

The special terms and conditions (STCs) associated with the August 22, 2000, approval of the Phase 2 amendments and the STCs associated with the July 2, 2001, approval of the county-based purchasing amendments apply to this extension. In response to your letter, the STCs have been revised to include budget neutrality trend rates of 7.36 percent for children and 8.0 percent for adults. Budget neutrality will be assessed over the life of the demonstration.

The List of Sections Waived and Costs Not Otherwise Matchable are enclosed as well as the revised STCs reflecting the budget neutrality trend rates above.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable to this letter, shall apply to the Minnesota demonstration.

Our approval of this revised extension of PMAP+ is contingent upon your continued compliance with the approved STCs set forth for this demonstration. This revised extension is subject to our receiving your written acceptance of the STCs within 30 calendar days of the date of this letter.

We look forward to the continued success of this project. If you have any questions regarding this approval, please contact Mr. Joseph Millstone, Project Officer, at (410) 786-2976.

Sincerely,

/s/

Thomas A. Scully
Administrator

Enclosures

Section 1115 Demonstration Project, No. 11-W-00039/5
"Minnesota Prepaid Medical Assistance Project Plus (PMAP+)"

List of Sections Waived

Under the authority of Section 1115(a)(1) of the Social Security Act (the Act), the following waivers of provisions of the Act are in effect to enable Minnesota to carry out the PMAP+ demonstration:

1. Section 1902(a)(1) of the Act as implemented by 42 CFR 431.50 and 434.25(a)(2)

   This waiver exempts the State from the requirement to administer medical assistance uniformly on a Statewide basis.

2. Section 1902(a)(23) of the Act, as implemented by 42 CFR 431.51

   This waiver permits the State to restrict the recipient's freedom-of-choice of provider.

3. Section 1902(a)(30) - as implemented by 42 CFR 447.361

   Section 1902(a)(4) - as implemented by 42 CFR 434.23

   This waiver permits the State to prepay for 90 days of nursing facility (NF) care, and vary payment methodologies to provide quality improvement incentives.

4. Section 1902(a)(10) of the Act as implemented by 42 CFR 440.240(b)

   This waiver allows differences in the amount, duration, and scope of benefits provided to recipients.

5. Section 1902(a)(4)(A) - as implemented by 42 CFR 431.806(a), 431.810-431.816, 431.820-431.822, and 431.865. Section 431.804 is also waived, except that the regulatory definitions of "claims processing error" and "state agency" shall continue to be applicable to the State. "Claims processing error" should also apply for a service not authorized under the terms of the demonstration.

   This waiver enables the State to employ an MEQC system which varies from that required by the cited statutes and regulations.

Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of the project, be regarded as expenditures under the State's Title XIX plan.

1. Expenditures for capitation payments provided to managed care organizations which restrict enrollees' right to disenroll within 90 days of enrollment in a new MCO, as designated under Section 1903(m)(2)(A)(vi) and Section 1932(a)(4). Enrollees may change managed care organizations once within the first year of enrollment, and annually thereafter, except that with respect to enrollees in the South Country Health Alliance, enrollees will be able to change primary care physicians every thirty days.

2. Expenditures for prepaid capitation payments to non-health maintenance organizations, as designated under Section 1903(m)(2)(A)(i) and 42 CFR 434.20.

3. Expenditures to permit Medicaid coverage to children through age 20 and pregnant women with incomes at or below 275 percent of the federal poverty level, who would not otherwise be eligible for Medicaid.

4. Expenditures to permit Medicaid coverage to parents and caretaker relatives of children who are enrolled in this demonstration or under the Medicaid State Plan with family incomes at or below 275 percent of the federal poverty level who would not otherwise be eligible for Medicaid.

5. Expenditures for medical assistance provided to medically needy Medical Assistance recipients who are enrolled in this demonstration, who are determined to be eligible for a 12-month period, and who are in recipient households either only receiving unvarying unearned income or income solely from a source which by law cannot be counted as income, to the extent that these individuals would have been ineligible for Medicaid had the State determined their eligibility under a budget period of not more than six months under 42 C.F.R. 435.831(a)(1). This authority will permit Federal financial participation in expenditures for these individuals whose ineligibility for reasons other than income might have been detected had they been subject to the normal budget period rules.

6. Expenditures to permit Medicaid coverage to families enrolled in the demonstration who have received extended assistance under Section 1925(a) of the Act, to the extent that they would be ineligible for coverage if they were to comply with the quarterly reporting requirements of Section 1925 (b)(2)(B) because their income exceeds 185 percent of the gross family earned income, less child care expenses, during the second six-month period.

7. Expenditures to permit Medicaid coverage to pregnant women enrolled in the demonstration to the extent that they would be ineligible for automatic eligibility after the end of the post-partum period under Section 1902(e)(4)(5), in that coverage would be provided past the end of the post-partum period to the time of the household's next regularly scheduled eligibility review date, provided they were eligible for Medical Assistance prior to their pregnancy under another basis or live with other eligible household members subject to the same basis and income limits.

8. Expenditures to permit Medical Assistance payments for the cost of medical education to a medical education trust fund for direct distribution to teaching entities. FFP will be made available once the expenditures have been made distributing the payments to teaching entities.

9. Expenditures to permit Medicaid coverage to beneficiaries enrolled in the demonstration who receive gifts of money that do not exceed $ 100 per month, who might not be eligible for coverage if this gift were reported and included as countable income when determining program eligibility.

10. Expenditures to permit Medicaid coverage of services to pregnant women described in Section 1902(a)(10)(VII), to the extent that services are provided that are in addition to services related to pregnancy and conditions which may complicate pregnancy.